DBT Notes

Clinical Psychology (Amity University)

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DBT NOTES

MODULE I INTRODUCTION (20% WEIGHTAGE)

- ☐ Borderline Personality Disorder: Concepts.
- ☐ Treatment overview and goals of DBT.
- ☐ Interpersonal therapy: Concepts

Borderline Personality Disorder: Concept

1. Borderline personality disorder is a mental health disorder that impacts the way you think and feel about yourself and others, causing problems functioning in everyday life. It includes self-image issues, difficulty managing emotions and behavior, and a pattern of unstable relationships.
2. Borderline personality disorder is one of a group of conditions called “Cluster B” personality disorders, which involve dramatic and erratic behaviors. Personality disorders are chronic (long-term) dysfunctional behavior patterns that are inflexible, prevalent and lead to social issues and distress.
3. Many people who live with borderline personality disorder don't know they have it and may not realize there’s a healthier way to behave and relate to others. Borderline personality disorder usually begins by early adulthood. The condition seems to be worse in young adulthood and may gradually get better with age.
4. While bipolar disorder is also characterized by wide fluctuations in mood and behavior, it’s distinct from borderline personality disorder (BPD). In BPD, mood and behavior change rapidly in response to significant stress, especially when interacting with other people, whereas in bipolar disorder, moods are more sustained and less reactive. People with bipolar disorder also have significant changes in energy and activity, unlike those with BPD.
5. Signs and symptoms of borderline personality disorder usually appear in your late teenage years or early adulthood. A troubling event or stressful experience can trigger symptoms or make them worse. Over time, symptoms usually decrease and may go away completely. Symptoms can range from manageable to very severe and can include any combination of the following:
    - Fear of abandonment.
    - Unstable, intense relationships.
    - Unstable self image or sense of self.
    - Rapid mood changes.
    - Impulsive and dangerous behavior.
    - Repeated self harm or suicidal behavior.
    - Persistent feeling of emptiness.
    - Anger management issues
    - Temporary paranoid thoughts.

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6. The DSM-5 describes Borderline personality disorder as “a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning in early adulthood and present in a variety of contexts.” The DSM-5 explains that patients may express disproportionate or inappropriate anger which can result in temper problems or physical fights. Patients may experience dissociative symptoms or paranoia when under stress
7. Dialectical behavioral therapy (DBT) is the most effective intervention for treating borderline personality disorder. DBT asserts that all aspects of the patients are interrelated. Therefore, a whole systems approach is taken. DBT is a form of cognitive behavioral therapy that incorporates mindfulness and acceptance while reducing judgment.
8. DBT views the negative behaviors associated with borderline personality disorder as learned behaviors. DBT accepts the painful feelings of the patient and teaches new coping skills from a position of empathy and understanding. Part of this includes the understanding that truth and reality are both subjective experiences (Van Dijk, 2013).
9. Emotional regulation is another important component of DBT. Part of this process includes helping the patient to recognize and label negative feelings. DBT also works to increase interpersonal skills, thereby reducing chaos in interpersonal relationships. Group therapy is one way of increasing interpersonal skills in a therapeutic setting. Another important component of DBT is that patients may call the therapist for brief coaching at any time (Van Dijk, 2013).
10. This feature of treatment is extremely important because recurrent crises are a reality of borderline personality disorder. Helping a patient through a crisis offers the clinician important insight into the precipitating cause of the patient’s acute anxiety, panic or depression. Helping a patient through a crisis also teaches the patient crisis-management skills that can be implemented in future crises (Borschmann and Moran, 2011).
11. The unsafe behaviors associated with borderline personality disorder are often the result of poor coping skills. Lack of coping skills has been associated with self-injury, both with and without diagnosis of borderline personality disorder. For example, very young teens often do not have access to adaptive or non-adaptive coping mechanisms. Leaving an unpleasant situation may be nearly impossible, and not all adolescents have access to alcohol and drugs. As more coping skills are available, they tend to depend less on self-injury other unsafe behaviors (Nock, 2009)
12. Dialectical behavior therapy (DBT) is a structured outpatient treatment developed by Dr Marsha Linehan for the treatment of borderline personality disorder (BPD). Dialectical behavior therapy is based on cognitive-behavioral principles and is currently the only empirically supported treatment for BPD. Randomized controlled trials have shown the efficacy of DBT not only in BPD but also in other psychiatric disorders, such as substance use disorders, mood disorders, posttraumatic stress disorder, and eating disorders.
13. Traditional DBT is structured into 4 components, including a skills training group, individual psychotherapy, telephone consultation, and therapist consultation team. These components work together to teach behavioral skills that target common symptoms of BPD, including an

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unstable sense of self, chaotic relationships, fear of abandonment, emotional lability, and impulsivity such as self-injurious behaviors.

14. The skills include mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. Given the often comorbid psychiatric symptoms with BPD in patients participating in DBT, psychopharmacologic interventions are oftentimes considered appropriate adjunctive care.
15. The term “dialectical” means the interaction of conflicting ideas. Within DBT, “dialectical” refers to the integration of both acceptance and change as necessities for improvement. Dialectical behavior therapy aims to address the symptoms of BPD by replacing maladaptive behaviors with healthier coping skills, such as mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance.
16. Linehan's DBT manual explains that the skills training group is designed to target behavioral skill deficits that are common to patients with BPD, including an unstable sense of self, chaotic relationships, fear of abandonment, emotional lability, and impulsivity. The focus is on teaching psychosocial skills that target these deficits through 4 skills training modules: core mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance.
17. **Mindfulness meditation skills** are focused on being fully in the present. These skills center on learning to observe, describe, and participate in all experiences, including thoughts, sensations, emotions, and things happening in the environment, without judging these experiences as "good" or "bad." For example, people with BPD may find themselves overwhelmed with emotions during an argument and may then act out on those feelings without considering the consequences. Mindfulness skills help people learn how to interpret and regulate these emotions, allowing them to step back and respond more appropriately.
18. **Interpersonal Effectiveness** focuses on teaching and practicing social skills that are effective in relationships. Many patients with BPD have a history of childhood abuse, neglect, or other forms of invalidation that made it difficult for them to form secure attachments early in life. They therefore often experience intense, unstable relationships in which they have trouble asserting themselves. The interpersonal strategies teach patients how to ask for what they need, say “no” to inappropriate demands, and cope with interpersonal conflict. The focus of these strategies is in learning to keep meaningful relationships, while also maintaining self-respect.
19. **Emotion Regulation Skills** are strategies for enhancing control over personal emotions. For individuals with BPD, emotions can be intense and labile. This often leads to the development of dysfunctional behaviors that are aimed at avoiding negative emotions. The emotion regulation skills first work on identifying and labeling emotions so that patients can understand how emotions can lead to behaviors affecting their overall functioning. The patients also learn to identify obstacles to changing their emotions, which often include dysfunctional behaviors that have been used by a patient for communication or validation of their experience.
20. **Distress tolerance skills** module promotes learning ways to accept and tolerate distress without doing anything that will make the distress worse in the long run, for instance, engaging in self-harm.When faced with strong emotion, a person with BPD may engage in

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impulsive or risky behaviors in order to escape what feels like an intolerable feeling. Substance use, violence, excessive alcohol use, and other risky actions are examples of behaviors someone might engage in to temporarily feel better and which may make things worse in the long-term. Distress tolerance skills allow people to learn how to better cope with such emotions and respond in ways that are more adaptive.

Treatment overview and goals of DBT

1. DBT is the combination of dialectical , cognitive behavioral and zen approaches. It is based on a biopsychosocial theory which focuses on a range of problems relating to emotional dysregulation, including substance abuse, eating disordered behavior, and anger related problems.
2. A therapist specializing in DBT focuses on making every reasonable effort to conduct competent and effective therapy. They obey the standard ethical and professional guidelines and maintain confidentiality. They are available to the patient for weekly therapy sessions and provide needed therapy backup.

Therapist's Role

3. Through **dialectical approach** the therapist highlights that opposites can coexist and be synthesized. They are dialectical and focus on balancing between acceptance and change.The therapists are non judgemental and tailor the therapy according to the client's needs. In therapy, they are also required to play the devil's advocate, activate wise mind and challenge their inner thoughts.
4. Through **cognitive behavioral and learning approach**, the therapist attends to both the antecedents and the consequences that control a specific cognitive behavior. Dialectical behavioral therapy (DBT) is a type of cognitive behavioral therapy as it tries to identify and change negative thinking patterns and pushes for positive behavioral changes. DBT may be used to treat suicidal and other self-destructive behaviors.
5. The **Zen approach** emphasizes that the world is perfect in the sense that it is the best it can be. It cannot be any different than it is because it is created or caused by what has preceded it.

The Four Stage Treatment Plan in DBT

Stage	Description
1	There are three targets for an individual DBT therapist in stage 1: To eliminate life-threatening behavior, to reduce therapy-interfering behavior and to reduce quality-of-life-interfering behavior This stage focuses on decreasing suicidal and self harm behaviour, those behaviours that undermine or interfere with therapy, quality of life and often lead to crisis. It focuses on changing core beliefs, as well. Some techniques to modify core beliefs are: ● Motivating patients to modify new beliefs. ● Modifying negative core beliefs daily.

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	● Reinforcing more realistic core belief daily. ● Contrasting with more extreme negative role models. ● Creating yardsticks of evaluation. ● Devising behavioral experiments. ● Doing intellectual emotional role plays. ● Cognitive continuum. ● Historical review of evidence. ● Restructuring the meaning of early experiences through imagery.
2	Increasing other required skills like mindfulness, interpersonal effectiveness, emotion regulation and distress tolerance and increasing respect for self. Stage 1 and 2 are not totally separate processes, they are applied simultaneously. The therapist moves on to the next stages when the first two stages are successfully achieved. ● Mindfulness skills: three 'what' skills (observing, describing, participating) and three 'how' skills (taking a non judgemental stance, focusing on one thing at the moment and being effective). ● Distress tolerance: provides 4 sets of strategies such as distracting, self soothing, improving the moment and thinking of pros and cons. ● Emotion regulation: identifying and labeling affect, identifying obstacles to changing emotions, reducing vulnerability to emotional events, increasing mindfulness to current emotion, taking opposite action and applying distress tolerance techniques. ● Interpersonal effectiveness skills: these skills are effective in aiding the individual to ask for what they need and saying no. It also helps in coping with interpersonal conflict. ● Self management skills: this skill refers to any attempt to control, manage or otherwise change one's own behavior, thoughts or emotional responses.
3	This stage focuses on returning the individual to their ordinary levels of happiness and unhappiness. Problems at this stage of treatment are of low to moderate severity and have only a moderate impact on client's functioning in comparison to stage 1 and 2. Stage 3 problems usually include those of marital discord, education or employment difficulties.
4	This stage aims to enhance the client's capacity for joy and focus on assisting clients through their insufficient ordinary happiness and unhappiness and feelings of meaninglessness or absence of connectedness. At this stage long term insight oriented therapies and spiritual or religious practices.

Goals of DBT

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1. The targets and goals of DBT differ for each stage of treatment but the overarching goal in DBT is to help the patient create a life worth living. This goes along with the idea that patients' lives are unbearable as they're currently being lived. And it is the therapist's job to help them develop their life worth living rather than ending life or simply bearing the unbearable existence that they have.
2. Life-threatening behavior: It is important to differentiate between life-threatening behavior and quality of life interfering behavior. And sometimes, that can be difficult for therapists to determine. Quality of life interfering behaviors would be things like substance abuse, impulsive sexual behavior, impulsive spending, being jobless, being homeless and other very difficult but not life-threatening behaviors such as eating disorders.
3. Therapy interfering behaviors: For effective therapy to occur, therapy interfering behaviors must be reduced. Behaviors such as arriving late for the session, or missing the appointment, interpersonal style of the patient and therapist's willingness to treat them can interfere with therapy and its progress. Therapy-interfering behaviors would also include any issues with intersession contact such as a patient calling too frequently or pushing or challenging the therapist's limits.
4. Quality of life interfering behaviors: In stage 1, the therapist is not only trying to reduce things but they are also trying to increase things as well. This is where the patient gets a psychoeducational experience and skills, where they are going to be learning how to self-validate, communicate effectively, ways in which they can regulate their emotions and how they can tolerate distress. In addition, they will be learning the formal practice of mindfulness.
5. Another of the goals of DBT is to keep the patient in the environment that they are in rather than to create a false environment. Sending a patient to a residential facility or hospitalizing them would be an example of an environment that was not a natural one. Through using these skills the therapist tries to help the patient and encourage them to utilize the learnt skills in the environment that they are in, rather than withdrawing them and putting them in a structured environment.
6. Another goal of DBT is to help the patient stay motivated. It is the role of the therapist particularly in the beginning and at various periods throughout treatment to help motivate the patient and encourage them to utilize these skills and keep going. According to the ladder analogy, the therapist would cheer for and remind the patient why it is so important despite how difficult it is to climb out, how important it is to keep going because the only alternative is to continue staying on in the unbearable environment that they are in.

Summary of goals

- ➢ DBT's main goal is to help patients create a life worth living.
- ➢ There are three targets for an individual DBT therapist in stage 1: To eliminate life-threatening behavior, reduce therapy-interfering behavior and reduce quality of life interfering behavior.
- ➢ Life-threatening behavior includes suicidal thoughts, urges and attempts as well as self-harm. A behavior is life threatening if it imminently threatens a patient's life.

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- ➢ Therapy-interfering behavior is anything that gets in the way of the patient receiving therapy or makes it more likely treatment will end prior to completion. Examples of therapy-interfering behavior include missing sessions, not completing homework, calling a therapist too frequently and arriving late for session.
- ➢ Quality of life interfering behaviors are anything which interferes with the patient creating their life worth living. Examples of quality of life interfering behavior include substance abuse, impulsive sexual behavior, impulsive spending and eating disorder behavior.

Interpersonal therapy:Concepts

1. Interpersonal psychotherapy was developed by Gerald Klerman (1929–1992). Interpersonal Psychotherapy (IPT) is a brief psychotherapy. Klerman approach identifies important interpersonal situations and suggests individualistic solutions for clients.that addresses interpersonal issues in depression to the exclusion of all other foci of clinical attention.
2. IPT focuses on the importance of interpersonal relationships in determining behavior and psychopathology. IPT does not necessarily assert that psychopathology arises from impaired relationships. But, problems are manifested in these relationships
3. Research has supported this idea
   - Individuals with depression have less supportive relationships
   - Individuals with other problems (e.g., alcohol abuse) more frequently have marital difficulties
   - Risk of relapse in depression increases when patients live with critical,negative family members.
4. In developing interpersonal psychotherapy, Klerman was influenced by both early theorists and research on depression. Adolf Meyer (1957) emphasized the importance of both the psychological and biological forces. According to Meyer, psychiatric disorders developed as individuals tried to adapt to their environment. Early experiences with both the family and various social groups influenced individuals' adaptation to their environment.
5. IPT has contributed numerous theories to the field of psychology:
   - Interpersonal theory- proposed by Harry Stack Sullivan demonstrated the importance of peer relationships in childhood and adolescence as they have an impact on later interpersonal relationships.
   - Attachment theory- proposed by J. Bowl suggested that humans have an innate tendency to seek attachments and that these attachments contribute to the survival of the species and to individual satisfaction.
   - View of human nature: although childhood experiences are important IPT regards current relationships as more important. They focus on the "here and now" framework.
6. Klerman studied psychological research on depression to determine which factors played a role in the onset of depression. Humans are vulnerable to depression if attachments do not develop early and attachment bonds are disrupted. Certain life events create stress that lead to depression. According to Klerman, some factors related to depression could be:

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- Loss of social relationships- research has shown that women who became depressed interacted poorly in social settings.
- Social and interpersonal stress in marriage may affect the development of depression- arguments between spouses have been related to the onset of depression.

7. Klerman (Klerman et al., 1984) was less concerned with the cause of depression than with helping individuals deal with the kinds of issues that affect their lives. Klerman believed that depression was the result of a variety of interpersonal issues and many of these may have been caused by difficulties in early relationships or problems of attachment within the family.
8. To deal with these, a brief treatment approach did not seem to be the most effective way to help individuals deal with their current symptoms of depression.Rather, he believed that there were four interpersonal problem areas that, if they could be alleviated, would help an individual deal with depression.
9. Role of therapist in IPT is one of those who advocate for the patient, is neutral, active and not passive. Therapeutic relationship is not a friendship and should not be interpreted as transference.

4 Areas of Social Dysfunction:

10. Grief: it is simply defined in IPT as "loss through death". In IPT the term is reserved specifically for bereavement. It can provide difficulties for people in mourning, particularly when the reaction is severe and continues over a long period of time.
11. Grief may present a particularly difficult problem when individuals experience the loss of more than one person who is close to them. Furthermore, some individuals are more prone to becoming depressed after losing a close friend or family member than are others. This reaction is often referred to as complicated bereavement.
12. Interpersonal Disputes: Often arguments, or disagreements with others, particularly on a continuing basis, can lead to depression.The dispute can be with a family member, spouse, child, parent, or other relative. At work it would be with a boss, a subordinate, or a coworker. The disagreement usually has to do with different expectations and communication problems between the person and the other party.
13. Role Transitions: Role transitions are situations in which the patient has to adapt to a change in life circumstances. Some are planned for and some are not. Examples of developmental changes are going to college, getting engaged or married, separating or divorcing, dealing with difficult children, or having a child leave the home. Sometimes role transitions have to do with work, such as trying to find a job, dealing with promotion or demotion, or being fired or laid off.
14. Other role transitions may be accidental or not predictable. In those who develop depression, these transitions are experienced as losses and hence contribute to the development of psychopathology. Individuals who are prone to depression may, when faced with one of these situations, see their situation as hopeless or out of control.
15. Interpersonal Deficits: the individual usually demonstrates a history of problems in beginning or maintaining a relationship with family, friends or significant others. The person talks about feeling lonely and separate from others. Although these feelings are longstanding, they may

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become worse after one of the other problems surfaces. When individuals do not report recent events that may have caused depression, this category is often used.

Goals of IPT

1. Interpersonal therapy fosters personal growth as well as symptom relief for emotional difficulties. According to the theory, patients can make behavior changes to alleviate mental health symptoms and increase confidence to manage emotional problems when they can both gain insight about how their early learning in family of origin relationships translates to present-day relationship patterns and learn and practice new, more adaptive ways of connecting.
2. Most patients can benefit from the approach of working collaboratively to resolve/manage/negotiate their problems and activate change mechanisms. Individuals with severe and persistent mental illness may need a more structured, skills-based approach, though, before focusing on interpersonal work.
3. IPT does little to explore the underlying issues brought on by previous traumatic experiences. Instead, its main objective is to enhance your social functioning and interpersonal relationships to lessen your emotional distress. Interpersonal therapy acknowledges that relationship problems can also contribute to depression, which is not always a “personal issue.”
4. The goals of interpersonal therapy (IPT) are to help you communicate better with others and address problems that contribute to your depression. Several studies found that IPT may be as effective as antidepressant medication for treating depression. Psychiatrists will sometimes use IPT together with medication.
5. Better relationships: IPT can assist patients in realizing the impact their relationships have on their lives. The two objectives are improving patients’ social interaction and lessening depressive symptoms.
6. Reduced depressive symptoms: Relationships play a role in depression. In other words, having or losing relationships can affect your depression, which might affect your relationships. IPT aims to lessen your depression symptoms by enhancing your interpersonal relationships.
7. IPT aids in reestablishing interest in relationships and to become involved in both relationships and activities. THey are helped to develop strategies to resolve the dispute or to bring about a change in an impasse. Sometimes they may change their expectations of their problems and relationships with others.
8. IPT further encourages the client to view the new role as more positive, develop a sense of mastery of the new role and increase self esteem, develop new relationships or improve ones that may be superficial.

Techniques of Interpersonal therapy

1. A typical 12-16-week course of interpersonal psychotherapy consists of weekly, one-hour sessions. The treatment plan may be extended for an additional four or more weeks, depending on the severity of the depression.

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2. Interpersonal therapy consists of three stages: formulation, middle, and graduation. Depending on the intensity of your symptoms and the level of interpersonal anxiety, each phase can last three to five sessions.

Initial session

In the first stage, you evaluate your state of mind and current circumstances. The therapist also learns about your history, sources of social support, and previous relationships. The psychoeducational component of relating symptoms to situations and relationships is also present.

1. In dealing with depression the therapist uses inventories, explains depression as a medical illness and not as a personal weakness, explains the treatment associated with medication and treatment. The therapist allows the patient to assume the sick role, is supportive of them and provides them hope.
2. The therapist assesses the relation of depression with interpersonal context, wherein they review the current and past interpersonal relationships which may or may not relate to depressive symptoms. The therapist along with the patient determine the following:

- Nature of interaction with significant persons.
- Expectations of patient and significant persons from one another and whether these were fulfilled.
- Satisfying and unsatisfying aspects of the relationships.
- Changes the patient wants in the relationships.

3. Identification of major problem areas: the therapist determines the problem areas related to current depression and then sets the treatment goals. They also determine which relationship or aspect of relationships is related to depression and what might change in it.
4. The therapist explains the IPT concepts and contract, they outline the understanding of your problem, agree on treatment goals determining which problem area will be the focus. The therapist will describe the procedures of IPT, "here and now" focus, need for the patient to discuss important concerns, review of current interpersonal relations, discussion of practical aspects of treatment- length, frequency, times, fees, policy for missed appointments.
5. In the initial stage the therapist's encouragement and reassurance help build a therapeutic alliance with the patient.By coming up with a specific formulation of how the treatment is to proceed, the stage is set for the middle phase of therapy.

Intermediate Sessions

1. The interpersonal therapist uses different strategies for each of the four areas
    - Grief
    - Interpersonal dispute
    - Role transition
    - Interpersonal deficit

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2. Grief: while dealing with grief, facilitating the mourning process, helping the patient reestablish interest and relationships to substitute for what has been lost, are kept in mind as goals by the therapist.
3. The therapist reviews depressive symptoms, relating symptom onset to death of significant others, reconstructing the patient's relationship with the deceased, describes the sequence and consequences of events just prior to, during and after the death. They aid in exploring the associated feelings and consider possible ways of becoming involved with others.
4. Interpersonal disputes: while dealing with this problem area the therapist aims at identifying disputes, choosing a plan of action, modifying expectations or faulty communication to bring about a satisfactory resolution.
5. In case of depressive symptoms, the therapist relates the symptom onset to overt or covert dispute with significant others with whom the patient is currently involved. They determine the stages of dispute:
    - Renegotiation (calm down participants to facilitate resolution)
    - Impasse (increase disharmony in order to reopen negotiation)
    - Dissolution (assist mourning)
6. The therapist attempts to understand how the nonreciprocal role expectations relate to dispute by exploring the issues in the dispute, differences in expectations and values, likelihood of finding alternatives, and resources available to bring about change in the relationships.
7. In the second stage, the therapist applies various treatment approaches when dealing with one of the four categories of distress: grief, role dispute, role transition, and interpersonal deficit. Every session normally starts with a question from the therapist regarding recent happenings in your life.
8. The attention then shifts to how things have changed, whether you've noticed progress, and whether relationships have benefited. Your therapist will work with you to pinpoint interpersonal difficulties if there hasn't been any improvement or if symptoms have worsened.
9. Role transition: while dealing with this problem area the therapist aims at helping the patient to mourn and accept the loss of the old role, help the patient to regard the new role as more positive, restore self esteem by developing a sense of mastery regarding demands of new roles.
10. The therapist reviews and relates the depressive symptoms to difficulty in coping with some recent life change, review positive and negative aspects of old and new roles, explore feelings about what is lost, explore feelings about the chang itself, opportunities in the new role, realistically evaluate what is lost, encourage the development of social support system and of new skills called for in new role.
11. Interpersonal deficits: the therapist aims at reducing the patient's social isolation and encourages formation of new relationships. The therapist reviews the depressive symptoms and relates them to social isolation.

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12. They review significant relationships including their negative and positive aspects, explore repetitive patterns in relationships, discuss the patient's positive and negative feelings about the therapist and seek parallels in other relationships.

Termination

1. The focus on your increased confidence and sense of independence signals the conclusion of interpersonal treatment. During this session the therapist explicitly discusses the end of the treatment throughout therapy, feelings about ending therapy and normalizing them, reviewing and consolidating therapeutic gains.
2. They also focus on discussing the potential future interpersonal stressors and strategies to solve them, develop a contingency plan in the event of recurrence of depressive symptoms, review the available interpersonal supports and consider maintenance IPT.
3. The therapist explicitly discusses termination, acknowledges that termination is a time of grieving and moves towards recognition of independent competence. In case the patient does not observe much changes it is essential for them to know that they are not the ones to be blamed for lack of improvement.

Specific techniques during IPT

1. Exploratory techniques: An ability to use non directive techniques, to foster the client's own sense of competence and autonomy. It involves the use of open-ended questions, allows the client to elaborate what they are feeling and extension of productive topics.
2. Clarification: An ability to use clarificatory techniques, asking the client to rephrase what they have said.
3. Communication analysis: An ability to engage the client in reporting and reflecting on a recent, difficult exchange/conflict with another person. It is an ability to help the client to focus on the verbal and non-verbal level of the exchange (e.g. posture, tone of voice).
4. Use of therapeutic relationship: An ability to help the client explore and try out, within the therapeutic relationship, alternative ways of communicating. Its an ability to provide feedback to the client about how they may be coming across to others

Strength and weaknesses of IPT

Strengths:

- ➔ Short term in nature
- ➔ Encourage the patient to regain his/her ability to function well
- ➔ Lasts from 12-16 weeks
- ➔ Lasting effects up to 16 weeks

Limitations:

- ➔ Deals with depressive symptoms and family problems
- ➔ Not deal with psychotic disorders
- ➔ Dependent on completing 12-16 weeks

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